Department of Finance & Administration

Agency Benefits Coordinator Meeting

Cancel Request Form/ SQE

Special Enrollment Provisions

- Defined: The federal law, HIPAA, allows employees and dependents to enroll in coverage under certain conditions outside the annual Open Enrollment Period.

Life Events

- Life Events are qualifying events that result in adding dependents that are newly eligible. Examples:
  - Marriage Event
  - Birth/Adoption

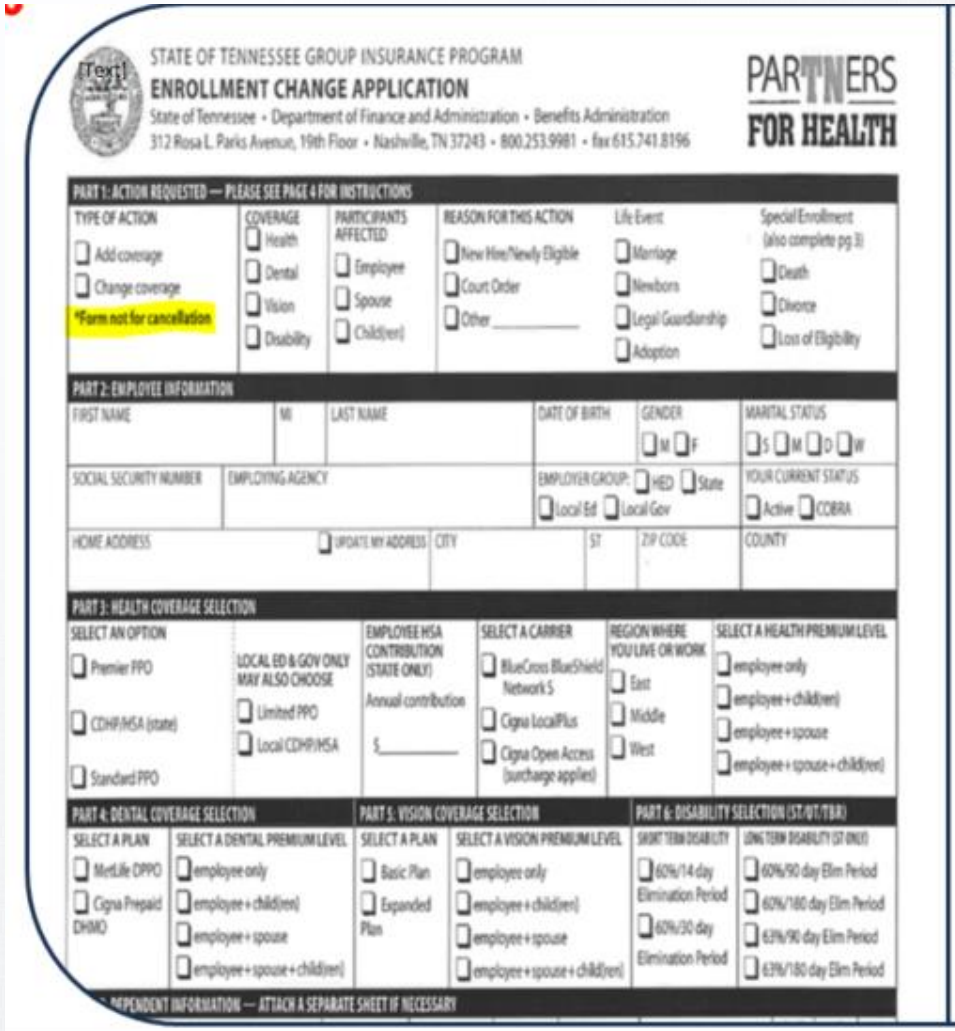
Special Qualifying Events

Enrollments that are a result of loss of coverage under another plan:

What Forms to Submit?

- Enrollment Change Application: This form should be used to **enroll** or **make changes** to coverage.
- Cancel Request Form: This form should be used to **terminate** coverage.
- Both forms list life event reasons and special qualifying event reasons because the employee is permitted to enroll or cancel under these provisions.
- When enrolling an employee or dependent due to a SQE or Live Event the application must be submitted within 60 days of the event.

Old vs. New: Enrollment Change Application



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

ENROLLMENT CHANGE APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration

312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 800.253.9981 • fax 615.741.8196

PARTNERS FOR HEALTH

PART 1: ACTION REQUESTED — PLEASE SEE PAGE 4 FOR INSTRUCTIONS

TYPE OF ACTION: Add coverage; Change coverage; *Form not for cancellation

COVERAGE: Health; Dental; Vision; Disability

PARTICIPANTS AFFECTED: Employee; Spouse; Child(ren)

REASON FOR THIS ACTION: New Hire/Newly Eligible; Court Order; Other _____

Life Event: Marriage; Newborn; Legal Guardianship; Adoption

Special Enrollment (also complete pg 3): Death; Divorce; Loss of Eligibility

PART 2: EMPLOYEE INFORMATION

FIRST NAME | MI | LAST NAME | DATE OF BIRTH | GENDER M F | MARITAL STATUS S M D W

SOCIAL SECURITY NUMBER | EMPLOYING AGENCY | EMPLOYER GROUP: HED State; Local Ed; Local Gov | YOUR CURRENT STATUS: Active; COBRA

HOME ADDRESS | UPDATE MY ADDRESS | CITY | ST | ZIP CODE | COUNTY

PART 3: HEALTH COVERAGE SELECTION

SELECT AN OPTION: Premier PPO; CDHP/HSA (state); Standard PPO

LOCAL ED & GOV ONLY MAY ALSO CHOOSE: Limited PPO; Local CDHP/HSA

EMPLOYEE HSA CONTRIBUTION (STATE ONLY): Annual contribution $_____

SELECT A CARRIER: BlueCross BlueShield Network S; Cigna LocalPlus; Cigna Open Access (surcharge applies)

REGION WHERE YOU LIVE OR WORK: East; Middle; West

SELECT A HEALTH PREMIUM LEVEL: employee only; employee + child(ren); employee + spouse; employee + spouse + child(ren)

PART 4: DENTAL COVERAGE SELECTION

SELECT A PLAN: MetLife DPPO; Cigna Prepaid DHMO

SELECT A DENTAL PREMIUM LEVEL: employee only; employee + child(ren); employee + spouse; employee + spouse + child(ren)

PART 5: VISION COVERAGE SELECTION

SELECT A PLAN: Basic Plan; Expanded Plan

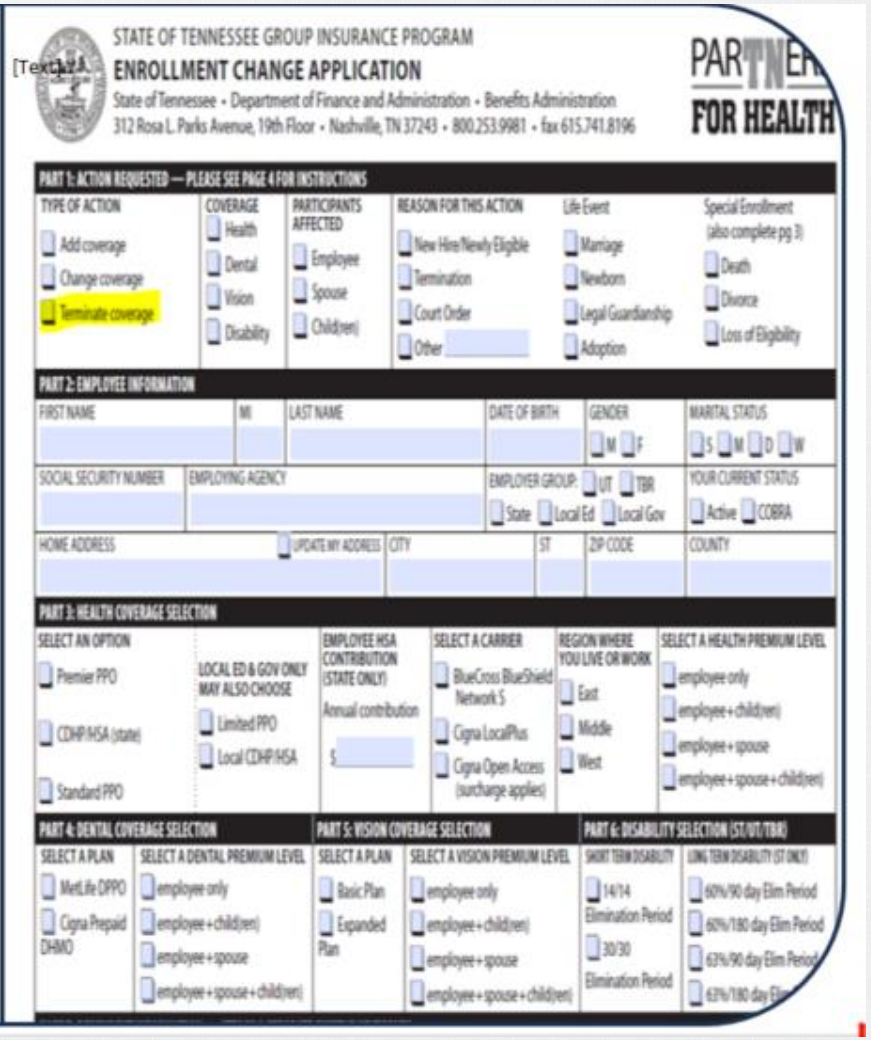
SELECT A VISION PREMIUM LEVEL: employee only; employee + child(ren); employee + spouse; employee + spouse + child(ren)

PART 6: DISABILITY SELECTION (ST/OT/TBR)

SHORT TERM DISABILITY: 60%/14 day Elimination Period; 60%/30 day Elimination Period

LONG TERM DISABILITY (ST ONLY): 60%/90 day Elim Period; 60%/180 day Elim Period; 63%/90 day Elim Period; 63%/180 day Elim Period

DEPENDENT INFORMATION — ATTACH A SEPARATE SHEET IF NECESSARY



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COVERAGE: Health; Dental; Vision; Disability

PARTICIPANTS AFFECTED: Employee; Spouse; Child(ren)

REASON FOR THIS ACTION: New Hire/Newly Eligible; Termination; Court Order; Other _____

Life Event: Marriage; Newborn; Legal Guardianship; Adoption

Special Enrollment (also complete pg 3): Death; Divorce; Loss of Eligibility

PART 2: EMPLOYEE INFORMATION

FIRST NAME | MI | LAST NAME | DATE OF BIRTH | GENDER M F | MARITAL STATUS S M D W

SOCIAL SECURITY NUMBER | EMPLOYING AGENCY | EMPLOYER GROUP: UT TBR; State; Local Ed; Local Gov | YOUR CURRENT STATUS: Active; COBRA

HOME ADDRESS | UPDATE MY ADDRESS | CITY | ST | ZIP CODE | COUNTY

PART 3: HEALTH COVERAGE SELECTION

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REGION WHERE YOU LIVE OR WORK: East; Middle; West

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SELECT A PLAN: Basic Plan; Expanded Plan

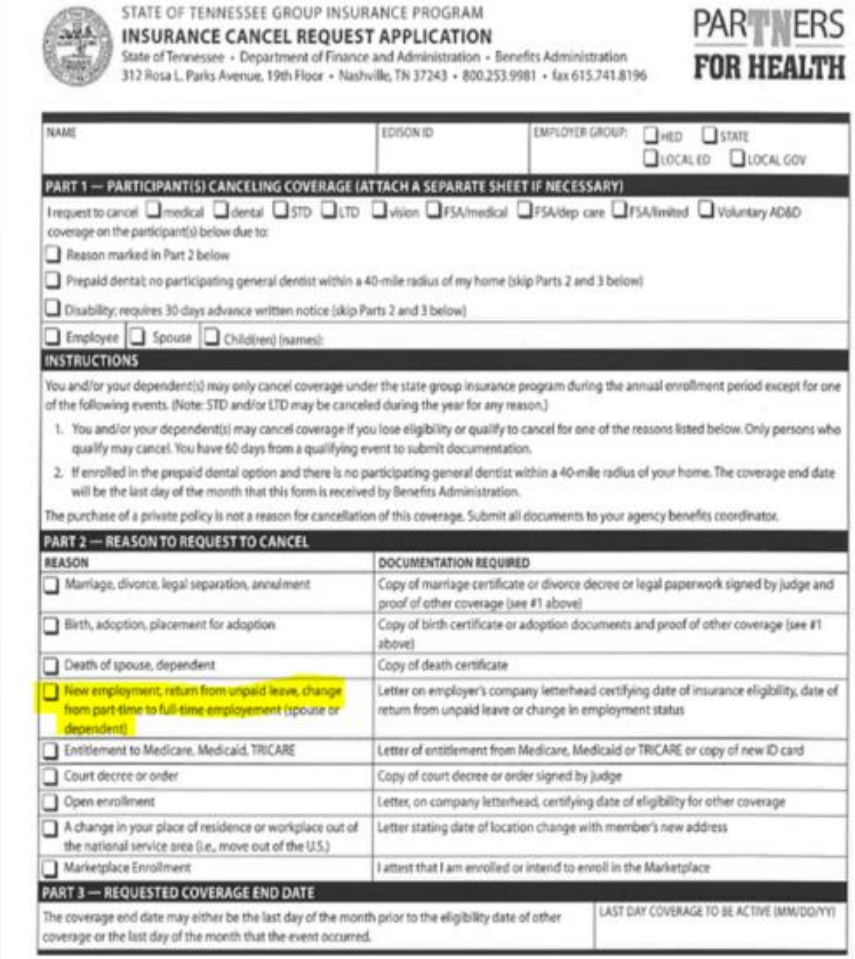
SELECT A VISION PREMIUM LEVEL: employee only; employee + child(ren); employee + spouse; employee + spouse + child(ren)

PART 6: DISABILITY SELECTION (ST/OT/TBR)

SHORT TERM DISABILITY: 14/14 Elimination Period; 30/30 Elimination Period

LONG TERM DISABILITY (ST ONLY): 60%/90 day Elim Period; 60%/180 day Elim Period; 63%/90 day Elim Period; 63%/180 day Elim

Old vs. New: Cancel Request Form



STATE OF TENNESSEE GROUP INSURANCE PROGRAM
INSURANCE CANCEL REQUEST APPLICATION
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PARTNERS FOR HEALTH

NAME	EDISON ID	EMPLOYER GROUP: ☐ HED ☐ STATE ☐ LOCAL ED ☐ LOCAL GOV

PART 1 — PARTICIPANT(S) CANCELING COVERAGE (ATTACH A SEPARATE SHEET IF NECESSARY)

I request to cancel ☐ medical ☐ dental ☐ STD ☐ LTD ☐ vision ☐ FSA/medical ☐ FSA/dep care ☐ FSA/limited ☐ Voluntary AD&D coverage on the participant(s) below due to:

☐ Reason marked in Part 2 below

☐ Prepaid dental; no participating general dentist within a 40-mile radius of my home (skip Parts 2 and 3 below)

☐ Disability; requires 30-days advance written notice (skip Parts 2 and 3 below)

☐ Employee ☐ Spouse ☐ Child(ren) (names):

INSTRUCTIONS

You and/or your dependent(s) may only cancel coverage under the state group insurance program during the annual enrollment period except for one of the following events. (Note: STD and/or LTD may be canceled during the year for any reason.)

1. You and/or your dependent(s) may cancel coverage if you lose eligibility or qualify to cancel for one of the reasons listed below. Only persons who qualify may cancel. You have 60 days from a qualifying event to submit documentation.
2. If enrolled in the prepaid dental option and there is no participating general dentist within a 40-mile radius of your home. The coverage end date will be the last day of the month that this form is received by Benefits Administration.

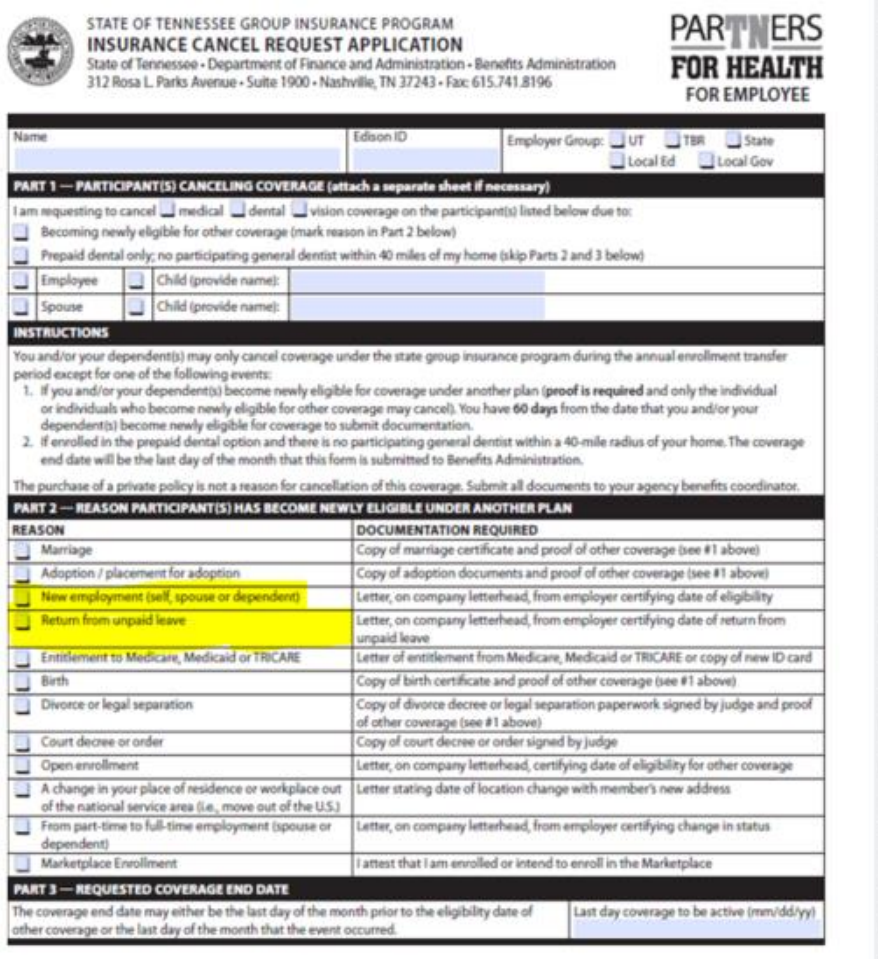
The purchase of a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordinator.

PART 2 — REASON TO REQUEST TO CANCEL

REASON	DOCUMENTATION REQUIRED
☐ Marriage, divorce, legal separation, annulment	Copy of marriage certificate or divorce decree or legal paperwork signed by judge and proof of other coverage (see #1 above)
☐ Birth, adoption, placement for adoption	Copy of birth certificate or adoption documents and proof of other coverage (see #1 above)
☐ Death of spouse, dependent	Copy of death certificate
☐ New employment, return from unpaid leave, change from part-time to full-time employement (spouse or dependent)	Letter on employer's company letterhead certifying date of insurance eligibility, date of return from unpaid leave or change in employment status
☐ Entitlement to Medicare, Medicaid, TRICARE	Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new ID card
☐ Court decree or order	Copy of court decree or order signed by judge
☐ Open enrollment	Letter, on company letterhead, certifying date of eligibility for other coverage
☐ A change in your place of residence or workplace out of the national service area (i.e., move out of the U.S.)	Letter stating date of location change with member's new address
☐ Marketplace Enrollment	I attest that I am enrolled or intend to enroll in the Marketplace

PART 3 — REQUESTED COVERAGE END DATE

The coverage end date may either be the last day of the month prior to the eligibility date of other coverage or the last day of the month that the event occurred.	LAST DAY COVERAGE TO BE ACTIVE (MM/DD/YY)



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INSURANCE CANCEL REQUEST APPLICATION
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PARTNERS FOR HEALTH FOR EMPLOYEE

Name	Edison ID	Employer Group: ☐ UT ☐ TBR ☐ State ☐ Local Ed ☐ Local Gov

PART 1 — PARTICIPANT(S) CANCELING COVERAGE (attach a separate sheet if necessary)

I am requesting to cancel ☐ medical ☐ dental ☐ vision coverage on the participant(s) listed below due to:

☐ Becoming newly eligible for other coverage (mark reason in Part 2 below)

☐ Prepaid dental only; no participating general dentist within 40 miles of my home (skip Parts 2 and 3 below)

☐	Employee	☐	Child (provide name):
☐	Spouse	☐	Child (provide name):

INSTRUCTIONS

You and/or your dependent(s) may only cancel coverage under the state group insurance program during the annual enrollment transfer period except for one of the following events:

1. If you and/or your dependent(s) become newly eligible for coverage under another plan (**proof is required** and only the individual or individuals who become newly eligible for other coverage may cancel). You have **60 days** from the date that you and/or your dependent(s) become newly eligible for coverage to submit documentation.
2. If enrolled in the prepaid dental option and there is no participating general dentist within a 40-mile radius of your home. The coverage end date will be the last day of the month that this form is submitted to Benefits Administration.

The purchase of a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordinator.

PART 2 — REASON PARTICIPANT(S) HAS BECOME NEWLY ELIGIBLE UNDER ANOTHER PLAN

REASON	DOCUMENTATION REQUIRED
☐ Marriage	Copy of marriage certificate and proof of other coverage (see #1 above)
☐ Adoption / placement for adoption	Copy of adoption documents and proof of other coverage (see #1 above)
☐ New employment (self, spouse or dependent)	Letter, on company letterhead, from employer certifying date of eligibility
☐ Return from unpaid leave	Letter, on company letterhead, from employer certifying date of return from unpaid leave
☐ Entitlement to Medicare, Medicaid or TRICARE	Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new ID card
☐ Birth	Copy of birth certificate and proof of other coverage (see #1 above)
☐ Divorce or legal separation	Copy of divorce decree or legal separation paperwork signed by judge and proof of other coverage (see #1 above)
☐ Court decree or order	Copy of court decree or order signed by judge
☐ Open enrollment	Letter, on company letterhead, certifying date of eligibility for other coverage
☐ A change in your place of residence or workplace out of the national service area (i.e., move out of the U.S.)	Letter stating date of location change with member's new address
☐ From part-time to full-time employment (spouse or dependent)	Letter, on company letterhead, from employer certifying change in status
☐ Marketplace Enrollment	I attest that I am enrolled or intend to enroll in the Marketplace

PART 3 — REQUESTED COVERAGE END DATE

The coverage end date may either be the last day of the month prior to the eligibility date of other coverage or the last day of the month that the event occurred.	Last day coverage to be active (mm/dd/yy)

Questions?